Signature on File

- I authorize the use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize AppleTree Therapy, LLC to act as my agent by helping obtain payment from my insurance companies.
- I authorize payment directly to AppleTree Therapy, LLC.
- I permit a copy of this authorization to be used in place of the original.

Printed Name: _____

Signature:_____

Date: _____